CHAPTER 3

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Benefits

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq*.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. Health Benefits Plan Committee. A Health benefits plan committee was appointed pursuant to W.S. § 35-25-105, and submitted a list of recommended minimum services to the Department. That list comprises the basic level of benefits. Only those health insurance plans which provide the basic level of benefits as specified in this Chapter may be approved for participation in the program.

Section 4. Basic Level of Benefits. Health insurance plans must include coverage for at least the following services when medically necessary, subject to a one million dollar ($1,000,000.00) lifetime maximum benefit per child. Except as otherwise specified in this Section, coverage must be one hundred percent (100%), with no deductible or co-payments. Co-payments by insureds or their families shall be pursuant to Chapter 4.

(a) Abortion, if necessary to save the life of the mother or if the pregnancy is a result or an act of rape or incest.

(b) Comprehensive Outpatient Rehabilitation Facility (CORF) services, if prescribed or furnished by a physician or other practitioner.

(c) Inpatient mental health services, including:

(i) Services furnished in a State-operated mental hospital.

(ii) Services furnished in a residential or other twenty-four (24) hour

per day therapeutically planned structural setting.

(iii) Inpatient hospital services (first level) are limited to twenty-one (21) days per benefit year. Partial hospitalization may be exchanged for inpatient hospital services at the rate of two (2) days of partial hospitalization to one (1) day of inpatient services. Partial hospitalization must meet the standards established by the American Association for Partial Hospitalization, which are incorporated by this reference.

(A) Inpatient hospital services (second level) provides for an additional nine (9) days of care, for a total of thirty (30) days per benefit year, with pre-approval and case management by the insurance company. The insurance company will work closely with the provider to ensure treatment plans are in place and managed.

(B) Limitations. A child who is a patient in an institute for mental disease (IMD) shall not be eligible for Kid Care CHIP, unless the child applied for the program before becoming a patient in the IMD.

(C) Unlimited services. No service limitations shall be imposed on children diagnosed with the following disorders, as defined by the American Psychiatric Association:

(I) Schizophrenia;

(II) Schizoaffective disorder;

(III) Bipolar disorder;

(IV) Major depression;

(V) Panic disorder;

(VI) Obsessive-compulsive disorder; or

(VII) Autism.

(iv) Inpatient substance abuse treatment services and residential substance abuse treatment service.

(A) Benefit year limitation. The combined benefit for inpatient and outpatient alcohol abuse treatment, substance abuse treatment, or both, other than costs for medical detoxification, is limited to six thousand dollars ($6,000.00) per benefit year, before a lifetime benefit of twelve thousand dollars ($12,000.00) is met. After that, the benefit year limitation is two thousand dollars ($2,000.00).

(B) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(v) Laboratory and radiological services for diagnostic or therapeutic purposes.

(vi) Outpatient hospital services.

(vii) Outpatient mental health services (first level), including:

(A) Services furnished by a state-operated mental hospital; and

(B) Community-based services.

(C) Limitations.

(I) Twenty (20) visits per benefit year.

(II) Partial hospitalizations are covered as specified above.

(D) Outpatient mental health services (second level), provides for an additional twenty (20) outpatient visits per benefit year, for a total of forty (40) days per benefit year, with pre-approval and case management by the insurance company. The insurance company will work closely with the provider to ensure treatment plans are in place and managed. Providers will have the capability to bill for partial (thirty minutes or less) and full (more than thirty minutes) sessions. This capability only applies to the second level of benefits.

(E) Unlimited services. No service limitations shall be imposed on children diagnosed with the following disorders, as defined by the American Psychiatric Association:

(I) Schizophrenia;

(II) Schizoaffective disorder;

(III) Bipolar disorder;

(IV) Major depression;

(V) Panic disorder;

(VI) Obsessive-compulsive disorder; or

(VII) Autism.

(viii) Outpatient substance abuse treatment services.

(A) Benefit year limitation. The combined benefit for inpatient and outpatient alcohol abuse treatment, substance abuse treatment, or both, other than costs for medical detoxification, is limited to six thousand dollars ($6,000.00) per benefit year, before a lifetime benefit of twelve thousand dollars ($12,000.00) is met. After than, the benefit year limitation is two thousand dollars ($2,000.00).

(B) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(ix) Physician services provided by a physician, mid-level practitioner, or other covered provider, furnished in:

(A) The physician's office;

(B) A clinic;

(C) A patient's home;

(D) An outpatient surgery center; or

(E) A hospital.

(F) Routine physicals required for sports, employment, or government are covered.

(G) Anesthesia services are covered, if the surgical or hospital service which necessitates the anesthesia is covered.

(x) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, up to seven hundred and fifty dollars ($750.00) per benefit year.

(xi) Prenatal care and pre-pregnancy family services and supplies.

(xii) Prescription drugs; if prescribed by a practitioner acting within the scope of his or her practice, including;

(A) Chemotherapy drugs, if approved by the Food and Drug Administration.

(B) Vaccines;

(C) Prenatal vitamins; and

(D) Drugs necessitated by an organ or tissue transplant.

(E) Exclusions:

(I) Food supplements;

(II) Vitamins, other than prenatal; and

(III) Medical foods, other than those medically necessary to treat inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, if a medically accepted method or diagnosis, treatment, and monitoring exists.

(xiii) Spinal manipulation, up to two hundred fifty dollars ($250.00) per benefit year.

(xiv) Vision services.

(A) Services for the medical treatment of diseases or injury to the eye, if furnished by a physician or licensed optometrist.

(B) One vision exam per benefit year.

(C) One paid of lenses per benefit year, unless there is a change in the prescription.

(D) One pair of frames per benefit year up to one hundred dollars ($100.00) per benefit year. The family will be responsible for any amount in excess of one hundred dollars ($100.00).

(E) Contact lenses are covered up to one hundred dollars ($100.00) per benefit year. If the cost of the contacts is more than one hundred dollars ($100.00), families will be responsible for any additional cost.

(F) Either glasses or contacts for children, per benefit year, but not both. The program will not pay for both.

(xv) Well-baby and well-child care up to the recommendations of the American Academy of Pediatrics. Immunizations are covered up to approved age tables.

(xvi) Dental benefits. Exams, cleanings, bitewing x-rays, fluoride treatments, sealants, full mouth x-rays, space maintainers, fillings, simple extractions, emergency treatment for the relief of pain, pulpotomies and stainless steel crowns, gold

or porcelain crowns for teenagers with adult or permanent dentition, full-mouth debridement for teenagers with permanent dentition who have not seen a dentist in several years, partials for teenagers with permanent dentition missing anterior teeth, and sedation for younger children. Annual maximum is one thousand dollars ($1,000.00) per benefit year. Preventive and diagnostic services (exams, cleanings, fluoride, space maintainers, sealants, and x-rays) are subject only to frequency limitations, and are not included in the child's yearly benefit maximum.

(xvii) Emergency medical transportation.

(xviii) Durable medical equipment.

(xix) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. Rehabilitative services are limited to twenty-five thousand dollars ($25,000.00) lifetime, if furnished by a physician or other practitioner acting within the scope of his or her license in a home, school, or other setting recognized by State law.

(xx) Inpatient hospital services.

(d) The RFP may require additional or different services, in which case the RFP shall control.

(e) Exclusions. In addition to the limitations specified above, the following services are not covered, unless the participating insurance company elects to cover them:

(i) Acupuncture;

(ii) Administrative transportation;

(iii) Biofeedback;

(iv) Chiropractic services;

(v) Cosmetic surgery;

(vi) Custodial care;

(vii) Contractual services;

(viii) Hearing aids;

(ix) Obesity treatment;

(x) Orthodontia;

(xi) Organ transplants;

(xii) Personal comfort, hygiene, or convenience items;

(xiii) Private duty nursing;

(xiv) Radial keratotomy;

(xv) Routine foot care;

(xvi) Tissue transplants;

(xvii) TMJ treatment; and

(xviii) Any services for which other coverage is available.

(f) The RFP may specify additional or different excluded services or limitations, in which case the RFP shall control.

(g) No exclusions for pre-existing conditions. No health insurance plan shall be approved if it excludes any pre-existing condition.

(h) Denial of non-covered services. The denial of services because they are not covered services is not an adverse action, and the insured shall not be entitled to reconsideration or administrative hearing pursuant to Chapter 1 of the Medicaid rules. The insured shall be entitled to, and shall be notified of that entitlement, of his or her right to seek review pursuant to the review procedures established by the participating insurance company.